Parent or Guardian Authorization for Medical Treatment

I/We hereby authorize my son ___________________________ whose date of birth is ________________, to be treated by a liscensed, qualified physician who may be available if the family physician named below is unavailable:

Family Physician : _________________________________

City : ______________________ Phone : ________________________

Parent / Guardian signature: ___________________________ date:_______

Contact #'s :

Hm.___________________wk.__________________mbl _______________

Player Information

Allergies: _____________________________________

Blood type: _____________ Date of last tetanus shot: _________________

Health Ins. company: ______________________ Phone #:______________

policy #:_________

Additional information:

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